Larry F. Berman, M.D., M.S.P.H., P.C.

a professional corporation

Adult and Adolescent Internal Medicine
10620 Park Road, Suite 128 ♦ Charlotte, North Carolina 28210
Phone (704) 542-6111 ♦ Fax (704) 542-1239

Welcome to the Office!
New Patient Registration Sheet

Name: _____ Patient No: _____
(Last) (First) (Middle) (Office Use Only)
Home Address: _____Apt:_____

City: _____State: _____ Zip Code: _____
E-Mail Address_____
Home Telephone: ( ) _____ Cell Telephone_____
Date of Birth: _____ Social Security No: _____

Marital Status: (circle one) S M D W
Employer: _____ Address: _____
City: _____ State: _____ Work Telephone: ( ) _____
Who referred you to us?: _____
Emergency Contact: _____ Relationship: _____
Emergency Telephone: ( ) _____
Responsible Party: _____
(Last Name) (First Name)
Relationship: _____ Patient at this office?: Yes No

Health Insurance Information

Primary Insurance:
Name of Insured: _____
Birthdate: _____ Social Security Number: _____
Insurance Company Name: _____
Insurance Company Address: _____
Relationship of Patient to Policy Holder: Subscriber Spouse Dependent
(Circle One)
Policy Identification Number: _____ Group Number: _____

Secondary Insurance:
Name of Insured: _____
Birthdate: _____ Social Security Number: _____
Insurance Company Name: _____
Insurance Company Address: _____
Relationship of Patient to Policy Holder: Subscriber Spouse Dependent
(Circle One)
Policy Identification Number: _____ Group Number: _____

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Health & Social History

Full Name: _____ Date: _____

Age: _____ Birth date: _____ Occupation: _____

Please tell us why you are being seen today: _____

Are you presently taking any medication? If so, please list: _____

_____

Past Medical History: _____

_____

Family History of Medical Problems: _____

_____

Please list any allergies to medications: _____

Do you smoke? Yes No How much? _____ For how long? _____

Do you drink alcohol? Yes No How many drinks per day? _____
For how long? _____

Do you have a Living Will (Advance Directive)? YES NO

Authorization to Treat

I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such medical treatment as deemed necessary by Dr. Berman. I understand that I have the right to refuse to consent or refuse treatment at any time. I understand and agree that regardless of my health insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Date: _____ Signature: _____

Larry F. Berman, M.D., P.C.

Patient Financial Responsibility

Our office is doing everything possible to hold down the cost of medical care. Recognizing the need for our patients to have clear understanding of their financial responsibility for medical services, we have established the following policy:

1. All co-pays, deductibles and co-insurance must be paid at the time services are rendered. We accept cash, checks, and all major credit cards. A $25 fee will be charged for any returned check. We are members of most, but not all insurance plans. You are responsible for verifying what your insurance will cover and that we are providers on your plan.

2. We will bill your medical insurance company with a copy of your current insurance card. If you do not have your insurance card and we are unable to verify your coverage, full payment is due at the time of service.

3. If payment is not received from your insurance company within 60 days of the date of service any balance will be your responsibility.

4. You will receive at statement from our office after your insurance company's response. If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement and prior to any additional office visit.

5. If you do not have insurance or if the services provided are not covered by your insurance, payment in full is expected at the time that services are rendered.

6. All accounts 90 days past due will be turned over to a collection agency and our office may cease providing services to you.

7. All appointments require a 24 hour notice for cancellation and scheduled procedures require a 48 hour cancellation notice. We understand that emergencies arise, but appreciate your consideration of their policy. If three such occurrences take place, you may be dismissed from the practice. Failure to present for your appointment or give the required notice will result in a $25 missed appointment fee or a $50 missed procedure fee.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. We value you as a patient and look forward to the opportunity to provide you with the best possible care.

I have read and understand the financial policy set forth by Larry F. Berman, MD.

Patient Name (Printed):_____ D.O.B._____

Signed:_____ Date:_____

Larry F. Berman, M.D., P.C.

Receipt of Notice of Privacy Practices

I, _____, have received a copy of Larry F. Berman, M.D., P.C.'s Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Larry F. Berman, M.D., P.C.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Larry F. Berman, M.D., P.C. to use and/or disclose certain protected health information (PHI) about me to:

_____
(Name of entity to receive this formation)

This authorization permits Larry F. Berman, M.D., P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detailed to be released, origin of information, etc.):

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____ (typically, patients write "indefinite" here).

The practice will _____ will not __**X**__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Larry F. Berman, M.D., P.C. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

10620 Park Rd. Suite 128
Charlotte, NC 28210

_____ _____
(Signature of patient or legal guardian) (Relationship to patient)

_____ _____
(Patient's name printed) (Date)

_____

(Print name if legal guardian)

PATIENT/GUARDIAN MAY BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION

Health History Questionnaire: Larry F Berman, MD

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care

☐ Other (please briefly describe)_____

Special Communication Needs:			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Visual impairment	☐ Yes ☐ No	Cognitive impairment	☐ Yes ☐ No
Hearing impairment	☐ Yes ☐ No	Sensory impairment	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	Other:	

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	Condition	Procedure	Year
☐ Hypertension	☐ Seizures	☐ Heart surgery	
☐ High cholesterol	☐ Headaches	☐ Carotid artery surgery	
☐ Diabetes	☐ Stroke	☐ Vascular surgery / stent	
☐ Heart attack or angina	☐ Prostate problem	☐ Abdominal aneurysm repair	
☐ Irregular heart rhythm	☐ Breast problem	☐ Hysterectomy	
☐ Congestive heart failure	☐ Urinary tract infections	☐ Gallbladder removed	
☐ Asthma	☐ Osteoarthritis	☐ Appendix removed	
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)	☐ Tonsillectomy	
☐ Pneumonia	☐ Thyroid problem	☐ Joint replacement	
☐ Gastroesophageal reflux disease	☐ Bleeding disorder	☐ Breast cancer surgery	
☐ Stomach ulcer	☐ Addiction Issues	☐ Prostate cancer surgery	
☐ Kidney problems	☐ Depression or anxiety	☐ Hernia	
☐ Liver disease/hepatitis	☐ Mental Illness	☐ Pacemaker	
☐ Colon cancer	☐ Other (please describe)	☐ Other (please describe)	
☐ Bowel/digestive problem			

Social History:
Please circle appropriate answers below and provide explanations where appropriate
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher
Occupation: Occupational concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful
Are there financial concerns that affect your ability to seek healthcare? ☐ No ☐ Yes If yes, describe below
Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period_____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies ___
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages___
☐ Vomiting blood	☐ Legs ☐ Neck ☐☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet		

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative		Condition	Relative
☐ Mental illness			☐ Chemical dependency	

Allergies:

Please list any allergies to medications or foods

Medications:	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency	

Health Maintenance:					
Please check whether you have had the following preventive services and enter the year of the service					
Immunizations		Year	Tests		Year
Tetanus vaccine / Tdap	☐ Yes ☐ No		Pap smear/pelvic	☐ Yes ☐ No	
Pneumonia vaccine	☐ Yes ☐ No		Mammogram	☐ Yes ☐ No	
Influenza vaccine	☐ Yes ☐ No		Bone dexa	☐ Yes ☐ No	
Shingles vaccine	☐ Yes ☐ No		Colonoscopy	☐ Yes ☐ No	
			Prostate test	☐ Yes ☐ No	

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other

Health Behaviors:			
Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker			
If current smoker how many packs per day for how many years_____			
Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_____			
Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current			
If past or current drug use describe:			
Exposure to secondhand smoke	☐ Yes ☐ No	Wear a seatbelt	☐ Yes ☐ No
Eat a diet high in fruits and vegetables	☐ Yes ☐ No	See a dentist at least once a year	☐ Yes ☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes ☐ No	Wear sunscreen	☐ Yes ☐ No

Advance Care Planning:			
Do currently have, or would you like information on, any of the following items			
Living Will:	☐ Have	☐ Don't Have	☐ Want Information
Durable Power of Attorney:	☐ Have	☐ Don't Have	☐ Want Information
DNR Order:	☐ Have	☐ Don't Have	☐ Want Information
Other:	☐ Have	☐ Don't Have	☐ Want Information

Urinary Incontinence Assessment

Do you experience leaking in the following situations?

	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐
During car trips	☐	☐	☐	☐

In the Past few Weeks:

Have you frequently experienced the need to urinate?	☐	☐	☐	☐
Have you experienced leaking before an urgent need to urinate?	☐	☐	☐	☐
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?	☐	☐	☐	☐
Have you experienced a pressing or immediate urge to urinate?	☐	☐	☐	☐
Have you noticed a change in your urination frequency?	☐	☐	☐	☐
Do you need to urinate more than 8 times every 24 hours?	☐	☐	☐	☐
Do you have to get up more than twice during the night to urinate?	☐	☐	☐	☐
Do you sometimes have to strain to urinate?	☐	☐	☐	☐

Fall Risk Screening

In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Mood Screening

A person's mood can have a strong influence on their health status and overall wellbeing.
Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Health Literacy Questionnaire

Many times in healthcare staff and providers use words that are unfamiliar to the general population. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree

I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	1 2 3 4 5 6 7 8 9 10
I feel that I remember the instructions given to me at my doctor's office when I get home	1 2 3 4 5 6 7 8 9 10
I feel that I have a strong understanding of medical language	1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ Date:_____